Georgia Department of Community Health
P.O. Box 38342, Atlanta, GA 30334; Fax: (404) 463-3444

RELEASE OF INFORMATION TO PERSONAL REPRESENTATIVE

Purpose: This form is used to confirm a patient's permission for the State Health Benefit Plan (SHBP) to discuss or disclose their Protected Health Information to a specific person who acts as their Personal Representative. A separate form must be completed for different patients from the same family.

Section A: Type of Information

- Protected Health Information (not including any psychotherapy notes)

Section B: Patient Information

Instructions: Read and complete the section below. Print clearly.

I understand that my personal health information will be released by State Health Benefit Plan to the individual(s) I appoint as my Personal Representative(s) in Section C.

Patient Name: _____

Address: _____

Telephone Number: _____ **Date of Birth:** _____

Policy Number (from ID card): _____

Second Policy Number (if covered under multiple SHBP plans): _____

Section C: Authorized Use and / or Disclosure

Instructions: Read and complete the section below. Print clearly.

Intended Use or Disclosure:
I authorize the discussion and / or disclosure of my personal health information with the individual(s) listed below for the purpose of assisting with the coordination of my State Health Benefit Plan. I understand that it is the policy of the State Health Benefit Plan not to release such information to other people, except those directly involved in my care, without my written permission.

Health Plan Authorized to Release Information: State Health Benefit Plan

Personal Representative:

Name: _____

Address: _____

Daytime Telephone Number: _____ **Last Four Digits of SS#:** _____

Member Policy Number:_____

Section D: Expiration and Revocation

Expiration: This authorization will expire (complete only one):

- ❑ On _____/_____/_____
  (mm) (dd) (yyyy)

- ❑ On occurrence of the following event (for example, upon the end of coverage under SHBP), which must relate to the individual or to the purpose of the use and/or disclosure being authorized.

_____

Right to Revoke: I understand that I have the right to revoke or discontinue this permission at any time, provided that I notify the State Health Benefit Plan in writing at the address below.

SHBP-HPU
P.O. Box 38342
Atlanta, GA 30334
***Fax:** (404) 463-3444*

Section E: Signature / Authorization

Instructions: Read and complete the section below. Sign and date.

With my signature below, I authorize the State Health Benefit Plan to discuss and/or disclose my personal health information for the purpose described above to the individual designated as my personal representative.

Patient Signature: **Date:**

Return the completed Personal Representative Form to:
SHBP – HPU
P.O. BOX 38342
ATLANTA, GA 30334

FAX: (404) 463-3444

Failure to provide all necessary information will result in the form being returned to you.